Title: Case management service standards Program: Ryan White Part B Section: Service delivery	Last review: 2023.04.01 Next review: 2024.02.01 Origination: 2019.08.06
Sponsor: Utah Department of Health and Human Services Policy owner: Ryan White Part B administrator Approved by: HEART program manager	

Contents

Section 1.0 Introduction

1.1 Acronyms

ART: Antiretroviral therapy
BS: Benefits specialist
CD4: Cluster of Differentiation 4
CM: Case manager/case management
CP: Care plan
DAP: Data, assessment, plan
DHHS: Utah Department of Health and Human Services
DLA-20: Daily Living Activities-20
HRSA: Health Resources and Services Administration
MCM: Medical case manager/medical case management
NASTAD: National Alliance of State and Territorial AIDS Directors
NMCM: Non-medical case manager/non-medical case management
PCN: policy clarification notice
PLWH: People living with HIV
PSA: Psychosocial assessment
QPR: question, persuade and refer
ROI: Release of information
RWB: Ryan White Part B program
SMART: Specific, measurable, achievable, realistic and time-bound

1.2 Definitions of terms

Action step: a plan with steps listed to achieve a specific goal in the CP. The purpose is to clarify required resources to reach the goal, formulate a timeline, and identify the responsible person to complete the task(s).

BS: works in conjunction with CM to ensure clients receive and/or maintain eligibility for the RWB. BS assists clients to access medical and support services and educate clients on RWB benefits.

CM agency: agency contracted by DHHS for the RWB to provide CM services.

Client record: location where protected client information and documentation is located, this includes ClientTrack and other as identified.

ClientTrack: the data system containing Utah RWB client records, which is administered by the DHHS and is accessible to authorized users.

CM: a social worker, social service provider, nurse or health provider that focuses on MCM or NMCM. The CM is involved with a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet client needs based on their circumstances.

HRSA: the federal entity that administers Ryan White funding.

MCM: includes all types of MCM encounters (e.g. face-to-face, phone contact, and any other forms of communication). MCM provides a range of client-centered activities focused on improving health outcomes along the HIV Care Continuum. Activities may be prescribed by an interdisciplinary team that includes other specialty care providers.

NMCM: provides client guidance and assistance to access medical, social, community, legal, financial, and other needed services.

Re-engagement: clients who re-establish care through a CM agency or HIV provider after a period of not receiving HIV primary care.

Service standards: establish the minimal level of service or care that an RWB funded agency or provider may offer within a state, territory or jurisdiction. Each RWB funded service category has service standards.

Transition: a change in level or location of service.

1.3 Service category and standards

CM activities consist of a collaborative process to assess, plan, facilitate, coordinate care, evaluate, and advocate for needed services based on client circumstances. CMs work with the client to identify appropriate resources and services to assist in meeting their medical, socioeconomic, and psychosocial needs. CM service standards established by the RWB describe the minimum service delivery standards to ensure consistent, quality care is implemented.

According to NASTAD, HIV/AIDS program service standards ensure high quality care and improve client and public health outcomes. NASTAD emphasizes service standards are essential to clients, service providers, RWB and quality management personnel. Service standards establish minimum service provision expectations for the client and define core components of each funded service category.

The RWB ensures benefits to the client and the CM agency through:

- A consistent process to develop service standards.
- Access to clearly defined CM service expectations.
- A framework to measure performance, improve quality of care, client satisfaction and health outcomes.
- Practices that support CM self-care. (see Appendix A)
- Promoting high quality CM services using evidence-based practices such as chronic disease management, which supports clients in maintaining independence and optimum health through early detection and effective management of chronic conditions. (see Appendix B)

To ensure PLWH in Utah receive the highest quality of care, service standards are developed through collaboration with other states, HRSA, NASTAD, the RWB and CM agencies.

1.4 Applicable RWB Universal Service Standards

- Access to care
- Records management
- Billing
- Staff requirements/personnel qualifications
- Eligibility determination/screening
- Client-related policies
  - Rights and responsibilities
  - Privacy and confidentiality
  - Grievance
  - Client retention
  - Re-engagement
  - Transition
- Quality management
- Fiscal
- Monitoring

Section 2.0 Case management service delivery

Not all PLWH need CM or on-going services to manage and maintain medical care. The focus of CM is to advocate, support, educate and assist the client in accessing community resources to meet current needs, decrease barriers to care and move towards self-sufficiency. (see Appendix C)

The CM:

- Provides proactive, holistic, RWB client-centered services. (see Appendix D)
- Uses a client centered-approach. (see Appendix E)
  Three elements are key to effectively practicing a client-centered approach:
  - Be unconditionally positive.
  - Be genuine.
  - Practice empathetic understanding.

The RWB is currently funded to provide NMCM and MCM (HRSA PCN #16-02).

NMCM:

- Works with clients who are self-sufficient and have one-time/short-term needs.
- Improves health outcomes through access to support services, adherence-related needs, psychosocial services coordination, and referral/follow-up based on the client's unique needs and barriers.

Clients appropriate for MCM may include those with complex medical needs, comorbidities or treatment adherence barriers to achieve or maintain viral suppression.

MCM:

- Has knowledge and training to manage client medical needs, and to participate with interdisciplinary team case review.
- Coordinates and provides specialized comprehensive intensive CM along the HIV care continuum.
- Works with the client to develop a CP.
- Coordinates care to ensure needs are identified, interventions are implemented, and health outcomes are improved.

CM follows service standards to coordinate access to appropriate levels of medical and support services. A client needs assessment will determine if services are provided in a community or clinic setting to support linkage to medical care and social services. Ongoing reassessment promotes continuity of care. CMs practice culturally competent and linguistically appropriate service provision. Interactions with clients may be face-to-face (in an office and/or clinic setting or in the field such as in a client's home or other public space), via telephone, or other form of communication tailored to client circumstances.

The level of CM is separated into three categories based on client evaluation during the assessment process. CM may be provided on a short or long-term basis.

Level of CM			
Assessment/evaluation	Self-management	NMCM	MCM
Engaged in care	✓	✓	
Adherent to HIV treatment	✓	✓	
DLA-20 score less than or equal to 6.0		✓	✓
Barriers to care identified		✓	✓
Needs education regarding HIV disease, risk reduction, and how treatment impacts positive health outcomes		✓	✓
Multiple co-morbidities and health conditions			✓
New HIV diagnosis			✓
HIV viral load greater than 200 copies/ml or unknown			✓

Section 3.0 Expectations and requirements

3.1 Policy and procedure expectations

Each agency providing CM services develops written policies and procedures pertaining to RWB clients. Policies are reviewed and updated as needed annually. See the RWB Universal Service Standards for more information on the following:

- Access to care
- Records management
- Billing
- Staff requirements/personnel qualifications
- Eligibility determination/screening
- Rights and responsibilities
- Privacy and confidentiality
- Grievance
- Client retention
- Re-engagement
- Transition

3.2 Caseload expectations

A caseload consists of a number of clients served under a professional provider (e.g., social worker, CM, nurse, teacher, etc.). The assigned caseload may vary depending on the setting, acuity, workload, expanded roles and holistic view of the client. An average caseload expectation for MCM is between 20-30 clients, and between 40-80 clients for NMCM.

An appropriately sized caseload supports effective communication with clients to assess, evaluate and provide CM services to meet client needs. A workload refers to direct and indirect services provided to and on behalf of the client to ensure compliance and quality of service. Services include, but are not limited to: travel, documentation, reports, research on resources, consultation and collaboration with interdisciplinary team, and family, etc.

3.3 Education requirements

Role	Minimum requirements
CM	One year of paid employment/professional experience providing CM services, excluding internships, AND one of the following: • Bachelor of Social Work. • Social Service Worker Certification (SSW). • Bachelor of Science in Nursing. • Bachelor degree in health or human services. OR Five years of paid employment/professional experience providing CM services, excluding internships.
CM supervisor	One year of paid employment/professional experience providing CM services, or other comparable experience in a social services or health associated field, working with PLWH or persons with history of mental illness, homelessness, or chemical dependence, excluding internships (one year of supervisory or clinical experience preferred), AND one of the following: • Licensed Clinical Social Worker (LCSW). • Master of Social Work (MSW). • Master of Science in Nursing (MSN).

3.4 Training requirements

Standard: training
• Agencies awarded RWB funding for MCM and/or NMCM complete training within six months of hire, then as specified or as needed for refresher. • Potential training opportunities are approved through the RWB administrator.

Expectation

Topic	Responsibility	Frequency
• HIV Testing and Counseling Harm Reduction Navigator • HIV medication 101	CM agency	one-time
• CP • DLA-20 • PSA • Transition	• CM agency • RWB provides updates	one-time
• QPR • ART (MCM)	CM agency	every 2 years
• ClientTrack • Clinical quality management plan • RWB manual • RWB service standards	• RWB • CM agency trains new staff	annual

Measure

Documentation of:

- Compliance with staff training expectations (this can be demonstrated through certification and/or attendance roster/sign-in sheets).
- Training in the employee personnel file.

Section 4.0 Case management functional roles

4.1 Assessment

Prior to completing DLA-20 and PSA:

- Ensure appropriate ROI is obtained and in client record.
- Gather information from client self-report and a variety of sources, including providers serving the client and others identified in the ROI.

4.1.1 DLA-20

A validated functional assessment tool used to assist planning and coordination of services for PLWH. It reliably assesses a client's functioning in 20 different areas of daily living. It guides prioritization of client needs, and determines the:

- Appropriate level of CM (see table *Level of CM*).
- Need for PSA and CP.

Standard: DLA-20
• The initial DLA-20 is completed within 30 business days after eligibility determination. • An updated DLA-20 is completed a minimum of every three months after the initial DLA-20 for clients enrolled in CM.
Expectation

• Complete the DLA-20 assessment face to face or through telehealth.
• Use the DLA-20 to:
  ○ Guide CM caseload to ensure even workload distribution.
  ○ Prioritize client needs when creating a CP.

Measure
Documentation of: • Initial DLA-20 completed within 30 business days after eligibility determination. • Updated DLA-20 is completed a minimum of every three months after the initial DLA-20 for clients enrolled in CM. • All interactions, correspondence and overall progress summary related to the DLA-20 within 24 business hours.

CM planning and coordination

DLA-20 score	Client contact	CM	
≤ 2.0 = extremely severe	weekly	• initial PSA • initial CP • update DLA-20 • update CP • update PSA	
2.1 – 3.0 = severe	twice monthly		
3.1 – 4.0 = serious	monthly		
4.1 – 5.0 = moderate	quarterly		
5.1 – 6.0 = mild	quarterly	adherent: update DLA-20	non-adherent (MCM): • initial CP • update DLA-20 • update CP
> 6.1 = adequate	self-management	close case	

4.1.2 PSA

A comprehensive evaluation of the psychosocial, medical, physical, mental, and emotional health. It is used to gather current and past events to determine needs and ability of the client to function within the community. The PSA provides a framework to guide discussion to identify needs and barriers and understand the client situation. It is used to assist with CP development including appropriate interventions and referrals.

Standard: PSA
For clients with a DLA-20 score ≤ 5.0: • The initial PSA is completed within 30 business days after the initial DLA-20. • An updated PSA is completed annually.
Expectation
• Complete assessment face to face or through telehealth. • Use the PSA as a guide to assess client resources and strengths, including family and other support, and to assist with CP development.
Measure
Documentation of: • Initial PSA completed within 30 business days after the initial DLA-20. • Updated PSA annually at a minimum. • All interactions, correspondence and overall progress summary related to PSA within 24 business hours.

4.1.3 CP

Directs services provided based on prioritization of needs identified in the DLA-20 and the PSA. This process supports client self-determination and empowers them to actively participate in the planning and delivery of services.

Standard: CP

• For clients with a DLA-20 score ≤ 5.0, the Initial CP is completed within 30 business days after the initial PSA.
• For clients who are non-adherent with DLA-20 score 5.1 to 6.0, the initial CP is completed within 30 business days after the DLA-20.
• For clients with a score ≤ 6.0:
  ○ A CP progress summary is completed a minimum of every six months.
  ○ Updated CP is completed a minimum of every six months.

Expectation

• Collaborate with client to:
  ○ Identify and prioritize needs based on results of the DLA-20 and the PSA.
  ○ Strategize activities to achieve optimal adherence, for example: medication management, medical appointments, lab tests as applicable.
  ○ Create SMART goals and action steps.
  ○ Provide support services and referrals consistent with the goals outlined in the CP.
  ○ Monitor and modify CP until goals are met.
• Communicate plans with the medical team and mechanism of feedback to ensure adherence as applicable.
• Educate on relevant topics (e.g. medication, side effects, general health literacy, and risk reduction).

Measure
Documentation of: • Initial CP within 30 business days after the initial PSA or DLA-20. • All interactions, correspondence and progress related to CP within 24 business hours. • A CP progress summary is completed a minimum of every six months. • Updated CP is completed a minimum of every six months. • SMART goals and action steps.

4.2 Treatment adherence

Taking medications as prescribed is important to achieve optimal outcomes in health and viral load suppression. Client barriers for HIV treatment adherence varies, and may include, but are not limited to: challenges related to new diagnosis, trauma, age, health education, psychosocial, neurocognitive issues, mental health, and substance use.

Standard: treatment adherence

A client receiving MCM services has:
• A medication/treatment adherence goal(s) in the CP based on needs identified in the DLA-20 and PSA.
• Interdisciplinary team case review every six months at minimum for clients who:
  o Are non-adherent with medication/treatment.
  o Are not virally suppressed.
  o Require special considerations due to management complexity.
The team may include physician, case manager, pharmacy or other care provider as indicated to coordinate care and facilitate treatment success for the client.
Documentation of case review includes:
  o Date.
  o Name of participants and interdisciplinary representation.
  o Issues and concerns.
  o Adherence barriers identified for the client with high viral load levels.
  o Plan for strategies and interventions.
  o Verification of plan implementation.

Expectation

• Work with client on treatment adherence to:
  o Develop the CP based on client needs, barriers, and readiness to engage in treatment.
  o Identify and offer available tools to support adherence such as: pillboxes, pocket-sized medication records, reminder sheets, text reminder systems, ART delivery, etc.
  o Establish linkages and relationships.
  o Schedule appointments and case review with providers and send appointment reminders.
• Communicate with the medical provider as needed (with appropriate ROI).

- Provide education on:
  - Undetectable = Untransmittable (U=U)
  - Medical appointments, and how to access appropriate support services.
  - Disease management and treatment adherence including:
    - Information and expectations for medications, and lab results (CD4, viral load).
    - Medication side effects, challenges, and barriers.
    - Importance of adherence, and consequence of missing doses.

Measure

Documentation of:

- Treatment adherence goal(s) as part of the CP.
- Interdisciplinary team case review every six months at minimum.
- Interactions, correspondence and progress summary related to treatment adherence within 24 business hours.

4.3 Referrals

Referral and follow-up may be indicated to meet client-specific needs and eliminate barriers.

Standard: referrals

- Referral initiated when client needs and barriers are identified.
- Referral follow-up within 14 business days.

Expectation

- The CM agency maintains a current list of internal and external providers and community services to support clients.
- Identify and facilitate client access to referrals appropriate to client situation, lifestyle, needs and barriers.
- Follow-up to monitor completion and outcome of referral.

Measure

- A current and comprehensive list of internal and external providers and community services to support clients.
- Documentation of referral:
  - Initiation when client needs and barriers are identified.
  - Follow-up within 14 business days.
  - Related interactions, correspondence and follow up within 24 business hours.

4.4 Re-engagement

In addition to the Universal service standards, specific CM expectations related to re-engagement are outlined below.

Standard: re-engagement
If client transitioned out of RWB and returns to CM services.
Expectation
Complete initial DLA-20 to determine needs and services. (see tables: Level of CM and CM planning and coordination)
Measure
Documentation within 24 business hours of interactions and correspondence related to re-engagement and related assessments.

4.5 DAP

The standard below is specific to CM. (see Universal service standards for general documentation guidelines and expectations)

Standard: DAP	
Utilization of DAP format for case note documentation pertaining to the client including: activities and interactions (in-person, emails, or phone conversations) with client, providers, or community agencies.	
Expectation	
***D**ata*	• What did the client say? • What did you observe? • Include both non-verbal and verbal communication.
***A**ssessment*	• What is the presenting situation? • What is the client's mental/physical state? • Include CM educational conclusion about the client situation.
***P**lan*	• Intervention to the overall client situation. • Identify next visit date (any topic to be covered by next visit). • What is your plan of action? • What are your and/or the client's responsibilities? • What is your follow up plan with the client?
Types of client-related interactions or activities:	
• assessment • problem • prognosis • interventions • application/recertification • CP	• treatment progress • interdisciplinary team case review • referrals and follow up • transitions of care (case transfer, closure and termination) • pertinent social, economic, and health factors
Measure	
Documentation: • Utilization of the DAP format. • Within 24 business hours of client interactions, information, correspondence or activities.	

Section 5.0 References

A General Overview of Effective Case Work Documentation for Adult Protective and Developmental Services Case Managers (State and Community) https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/documents/Case%20Work%20Notes%20Power%20Point.pptx

Ackerman, C. (2018, August 13). Client-Centered Therapy Carl Rogers' # 1 Person-Centered Technique. Retrieved December 12, 2018, from https://positivepsychologyprogram.com/client-centered-therapy/

Content Source: HIV.gov Date last updated: October 28, 2022. HIV Care Continuum. Retrieved April 14, 2023, from https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum

Content Source: HIV.gov Date last updated: October 27, 2023. U.S. Statistics. Retrieved April 14, 2023, from https://www.hiv.gov/hiv-basics/overview/data-and-trends/statistics

HIV/AIDS Care: Ryan White Program. (n.d.). Retrieved December 12, 2018, from https://healthcare.utah.edu/infectiousdiseases/ryan-white-program.php

Importance of Documentation and Best Practice in Case Notation https://www.seaetc.com/wp-content/uploads/2018/06/20180627-Importance-of-Documentation-and-Best-Practices-in-Case-Notation.pdf

National Monitoring Standards for Ryan White Part A and Part B Grantees: Universal Part A and B Ryan White HIV/AIDS Program Recipient Resources | Ryan White HIV/AIDS Program (hrsa.gov) https://ryanwhite.hrsa.gov/sites/default/files/ryanwhite/grants/fiscal-monitoring-partb.pdf

NASW Standards for Social Work Case Management. (2013). Retrieved December 12, 2018, from https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo=&portalid=0

Schaecher, K. L. (n.d.). The Importance of Treatment Adherence in HIV. Retrieved November 12, 2018, from https://www.ajmc.com/journals/supplement/2013/a472_sep13_hiv/a472_sep13_schaecher_s231?p=2

Service Standards for Ryan White HIV/AIDS Program (RWHAP) Part Programs. Retrieved April 14, 2023, from https://nastad.org/resources/service-standards-ryan-white-hivaids-program-rwhap-part-b-programs

Trauma-Informed Approaches Toolkit. (2019, February 27). Retrieved April 14, 2023, from https://nastad.org/trauma-informed-approaches-toolkit

Utah Ryan White Part B Program Manual | 2022. Retrieved from Ryan White Part B - Prevention, Treatment, and Care (utah.gov)

Zuluaga, M. E. (2017, January 02). The Stages of Change: A Model for Social Work Students in Field Placement. Retrieved December 12, 2018, from

http://www.socialworker.com/feature-articles/field-placement/the-stages-of-change-a-model-for-social-work-students-in-field-placement/

Section 6.0 Appendices

Appendix A: Self-care

Working in a stressful environment can create burnout for CMs. It is important for the CM to practice physical, emotional, and social self-care. Recognizing stress and implementing effective coping mechanisms improve self-care. Below are coping mechanisms from Substance Abuse and Mental Health Services Administration (SAMHSA) to consider when experiencing burnout.

Time management: • Make a daily plan of tasks. • Prioritize the list. Identify tasks that have to be done today (A's), from those which could be done tomorrow (B's), and tasks which are not that important (C's). You may need to adjust and revise your list. There may be times when reviewing your list with your supervisor is beneficial. • Be sure to do your "A" tasks first. • Keep list simple and realistic. • Carry your list with you – consult it often. • Let your list be your guide. • Set appointments with clients to provide CM services and stick with it. If they are not there for the appointment, reschedule. They will learn they can rely on you and they are responsible to be there on time. • Be on time. • Treat clients the way you want to be treated. • Always ask "what is the best use of my time right now?" • Do not always work on other people's "A" tasks at the expense of your own.
Stress management: • Talk with staff and your supervisor about your experience and feelings. • Sharing with others to reduce the tension and find humor in difficult situations. • Learn how to use relaxation exercises. • Use humor appropriately.
Recognize the burnout stages: • Stage I – Early warning signs: vague anxiety, constant fatigue, feelings of depression, boredom with one's job, apathy.

- Stage II – Initial burnout: Lowered emotional control, increasing anxiety, sleep disturbances, headaches, diffuse back and muscle aches, loss of energy, hyperactivity, excessive fatigue, and moderate withdrawal from social contact.
- Stage III – Burnout: skin rashes, generalized physical weakness, strong feelings of depression, increased alcohol intake, increased smoking, high blood pressure, ulcers, migraines, severe withdrawal, loss of appetite for food, loss of sexual appetite, excessive irritability, emotional outbursts, irrational fears (phobias), rigid thinking.
- Stage IV – Burnout: asthma, coronary artery disease, diabetes, cancer, heart attacks, severe depression, lowered self-esteem, inability to function on the job and personally, severe withdrawal, uncontrolled crying spells, suicidal thoughts, muscle tremors, severe fatigue, over-reaction to emotional stimuli, agitation, constant tension, accident proneness, and carelessness, feelings of hostility.
- Act to deal with your burnout if you recognize it.
- Talk to your supervisor for assistance.
- Take time-outs. These can be mini time-outs, such as taking the afternoon off, or longer vacations.
- It is okay to say you are having a difficult time. We all do at times. It is not okay to ignore the stress symptoms and do nothing about them.
- Cultivate pleasurable activities and hobbies that will offer you balance and peace.
- Develop a positive, nurturing support system.
- Set limits with yourself and others. Know your own boundaries.
- Exercise regularly.

Appendix B: Chronic disease management

Chronic disease management is an approach to health care which supports clients in maintaining independence and optimum health through early detection and effective management of chronic conditions. This approach prevents deterioration, reduces risk of complications, prevents associated illnesses, and enables people living with chronic conditions to have the best possible quality of life. A client's ability to follow medical advice, accommodate lifestyle changes, and access appropriate support are all factors that influence successful management of an ongoing illness. PLWH need support and information to become effective managers of their own health. Chronic conditions require both medical and behavioral interventions. Clients play a large role in managing chronic conditions such as HIV. Each client is unique, and appropriate interventions are customized to influence the client's desired outcomes. The following are essential to meet the needs of the client:

- Early access to and maintenance of comprehensive health care and social service
- Involvement in and optimal use of the health and social service systems
- Integration of services provided across a variety of settings
- Enhanced continuity of care
- Agreement on medical treatment goals for effective adherence
- Basic information about HIV and treatment
- Prevention of HIV transmission
- Understanding of medication adherence to control HIV and sustain viral suppression
- Understanding of, and assistance with, self-management skill building
- Ongoing support from members of the health care/CM team, family, friends, and the community
- Personal empowerment

Appendix C: Why is case management important for people living with HIV?

Current treatment has changed HIV significantly from what was once a perilous, terminal condition to a chronic, manageable disease. PLWH have the potential to live long, productive, fulfilling lives; however, many people experience significant barriers, which prevent them from accessing or receiving the benefits of available treatment options. The barriers and challenges present in the lives of many PLWH indicate that optimum HIV care requires a comprehensive approach in which CM services are of significant importance, as the CM links clients to services and treatment, and monitors delivery of care.

Not all PLWH need CM or on-going services to manage and maintain medical care. The focus of CM is to advocate, support, educate and assist the client in accessing community resources to meet current needs, decrease barriers to care and move towards self-sufficiency.

Regardless of educational background, CMs can provide effective CM to PLWH. This is enhanced through training in the following areas:

- CM process (intake, assessment, CP development and implementation, service coordination, monitoring, evaluation and documentation)
- Motivational interviewing
- Oral, written, and general communication skills
- Professional rapport and maintaining relationships
- RWB services and standards
- Community organization/resources
- Basic working knowledge of HIV/AIDS
- Basic understanding of ART
- Record keeping and documentation
- Knowledge of current HIV/AIDS standards of care
- Setting boundaries
- Cultural and linguistic competency
- Self-care
- Trauma informed approach

Appendix D: What is holistic case management?

CM uses a multi-step holistic approach to focus on mental, psychosocial, and physical aspects of health. This approach ensures timely access to services and resources needed to alleviate barriers.

CMs may be social workers, social service providers, nurses, health providers, or other professionals who work with clients to support them accessing care, removing barriers and bridging gaps to meet client needs. CM core emphases consist of:

Service: CM applies knowledge and skills to support bio-psychosocial well-being, and to address challenges faced by clients. CM prioritizes services to clients beyond professional or personal self-interest.

Social justice: CM pursues change to decrease poverty, discrimination, oppression, and other forms of social injustice experienced by clients. CM provides services in a culturally and linguistically appropriate manner and acts on client and systemic levels to ensure client participation in decision-making to access needed information, services, and resources.

Human dignity and worth: CM works with clients in a caring manner, respecting their self-determination, and valuing their strengths. CM strives to increase client capacity to improve situations and accomplish goals.

Integrity: CM acts in accordance with the mission and values of the organization and practices ethical principles and standards. They use the power inherent in the professional role responsibly. CM embarks on all actions with respect for clients' goals, exercising judicious use of self, avoiding conflicts of interest, and applying professional judgment in presenting resource options and providing services to clients.

Competence: CM practices within area of competence and persistently strives to develop knowledge and skills related to CM and the population served. CM recognizes self-care is essential to being present for clients and attends to self-care accordingly.

Appendix E: Client-centered approach to HIV case management

Carl Rogers is considered the founder of the client-centered approach, which he developed in the 1940s and 50s.

Three elements are key to effectively practicing a client-centered approach:
1. Be unconditionally positive.
2. Be genuine.
3. Practice empathetic understanding.

The essential principle of the approach is that all people have an innate inclination to strive toward growth, self-actualization, and self-direction. Comprehending how the client identifies resources and priorities for utilizing services to meet their needs is crucial for a client-centered CM relationship. One of the most difficult challenges for a CM is to see a client make a choice which may result in negative outcomes, and which are in conflict with the CM's best guidance. In these situations, the CM continues to nurture and encourage as the client experiences the consequences of their choices. This builds a trusting relationship between client and CM and provides a non-judgmental environment where the client feels safe to return when support is needed.

It is the CM's responsibility to:
- Offer accurate information to the client.
- Assist the client in understanding the implications of the issues facing them and of possible outcomes and consequences of decisions.
- Present options to clients from which they select a course of action or inaction.
- Offer direction when it is asked for, or when withholding it would place the client or someone else at risk for harm.
- Set appropriate boundaries and expectations.
- Advocate for the client.
- Show respect and dignity.
- Promote self-efficacy and self-sufficiency.
- Value and follow guidelines of privacy and confidentiality.

Approval group	Reviewed
RWB administrator: Seyha Ros	2023.03.24
Quality coordinator: Marcee Mortensen	2023.04.14
Senior RN quality consultant: Vinnie Watkins	2023.04.12
RWB fiscal analyst III: Anna Packer	2023.04.14
RWB financial manager I: Derrick Blomquist	2023.04.14
HEART program manager: Tyler Fisher	2023.05.05
Office of Communicable Diseases, director: Sam LeFevre	2023.05.09

Revised	Reviewer	Change description or location
2023.03.24	RWB administrator	Review all of the sections to ensure up to date information. Make changes to section 4.0
2023.04.12	Senior RN quality consultant and Quality coordinator	Aligned with DHHS formatting guidelines. Reviewed for alignment with HRSA PCN #16-02 and updated HRSA NMS (June 2022). Narratives to tables for readability and simplicity. Reduced redundant language. Updated appendices to reference document content.
2023.04.14	RWB Fiscal Analyst and Financial Manager	Add Fiscal to 1.4 and National Monitoring Standards Fiscal link
2023.04.14	RWB Administrator	Review all of the comments and made changes to section 3.4 and 5.0
2023.04.14	Quality coordinator	Reviewed grammar and formatting